Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	01	.	,	
HAL006007		B. WING		R 06/17/2015			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CRANBE	CRANBERRY HOUSE 6255 US HIGHWAY 19 EAST NEWLAND, NC 28657						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{C 000}	Initial Comments		{C 000}				
	Report of a Follow- Miller on June 17, 2	Up Construction Survey by Ed 2015.					
	11, 2015, Biennial (encies cited during the March Construction Survey, have not corrected and will require a tion.					
{C 189}	Building Equipment	t Maintained Safe, Operating	{C 189}				
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.						
	maintained in a saft barrier doors not late contain smoke and residents and staff fire in the fire comp Findings include: a. The smoke barr would not latch clost alarm system. b. The smoke barr would not latch clost alarm system.	vation, the facility was not e manner because of smoke tching properly in order to fire. This could affect all by not containing smoke and					
		the dining room would not					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Division of Health Service Regulation

Division of Health Service Regulation								
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	01	COMP	LETEU		
					F	}		
HAL006007		B. WING			7/2015			
NAME OF I	PROVIDER OR SUPPLIER	QTDEET AD	DRESS CITY S	STATE, ZIP CODE				
NAIVIL OI I	-NOVIDEN ON SUFFEIEN							
CRANBE	RRY HOUSE		HIGHWAY 19 D, NC 28657					
			1					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE		
{C 189}	Continued From page 1		{C 189}					
	work when tested. Battery powered emergency lights that will not work properly for at least 90 minutes could endanger the residents and staff.							
	function of several rework when tested.	vation, the battery back-up required exit signs would not Exit signs that do not work y or prevent an evacuation in om 106,						
	5. Based on observation, the sampling tubes for the duct mounted smoke detectors in the attic were dirty. Sampling tubes that are not periodically inspected and cleaned can endanger all residents and staff because the duct detector may fail to operate properly.							
	devices in the cover locking emergency alarm when opened	vation, the sounding alarm r for several of the magnetic release switches would not l. An alarm device that does w resident elopement.						
	too close to the ceil Storage that is not r	vation, storage was packed ing in the clean linen room. maintained 18 inches below could prevent the sprinkler ng properly in a fire.						
	drain line were exte Drain lines from foo are not maintained	vation, the juice dispenser nded into the floor drain. In producing appliances that at least 2 inches above the las required by Code, could provide to become						

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Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL006007	B. WING			R 17/2015
NAME OF PROVIDER OR SUPPLIER CRANBERRY HOUSE STREET ADDRESS, CITY, STATE, ZIP CODE 6255 US HIGHWAY 19 EAST NEWLAND, NC 28657						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{C 199}	provided with exhautwo cubic feet per in requirement does in before April 1, 1984 these specified spa (1) soiled linen stoi (2) soil utility room; (3) bathrooms and (4) housekeeping (5) laundry area. (k) This Rule shall facilities with the exwhich shall not appid the specified on observation maintain required expected the Non-functioning extended the specified in the specified specified in the	ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This ot apply to facilities licensed with natural ventilation in ces: rage; toilet rooms; closets; and apply to new and existing ception of Paragraph (e) ly to existing facilities.	{C 199}			

Division of Health Service Regulation

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